Print Reset

(Personal Service) (Mailed)

# VOLUNTARY PAYMENT FORM

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency/Board of Magistrates
P.O. Box 30016, Lansing, MI 48909

_____ Day of _____ 20_____

_____
Magistrate/Mediator (Please Print)

| Plaintiff | Defendant |
|---|---|
| Plaintiff's Social Security Number | Date of Injury |

The plaintiff and defendant agree that the plaintiff's Application for Mediation or Hearing is withdrawn. The defendant agrees to pay benefits on a voluntary basis in accordance with the following:

a. Weekly benefit rate $_____
Less benefits to be coordinated $_____
Subtotal $ 0.00
Plus supplemental benefit $_____
**TOTAL** $ 0.00
Benefits to be paid for the period from _____ through _____

b. Medical expenses to be paid? ☐ Yes ☐ No
If yes, to whom? _____

c. Reimbursement to group carrier? ☐ Yes ☐ No

d. Atty. fee to be charged Percent _____% Amount $_____
Atty. Fed. I.D.# _____

e. Amount of interest to be paid $_____

f. Additional agreements (attach additional sheets if necessary)

Neither the payment of compensation nor the accepting of same by the employee or his/her dependents shall be considered as a determination of the rights of the parties under this Act.

All benefits become due and payable on the day of personal service or the mailing date.

_____ _____
Plaintiff Defendant

_____ _____
Representative of Plaintiff Representative of Defendant

_____ _____
Date Magistrate/Mediator



**Authority: Workers' Disability Compensation Act 418.222; 418.223; 418.847; R408.33(2)(b). Completion of this form is voluntary. Penalty: None**